FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042697

Facility Name: SunBridge Care & Rehab - University

Address: 1095 University Drive (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: (618) 656-1081 **Fax #** (618) 656-7083

IDPA ID Number: 850370802-039

Date of Initial License for Current Owners: 6/1/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sylvia Moreno **Telephone Number:** (505) 468-4984

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/29/01 (Date)
(Type or Print Name) Dean Kiklis
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No Bed Changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,403	4,161	3,082	37,646	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,403	4,161	3,082	37,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.54%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 2,522

Medicare Intermediary TrailBlazer Health Enterprises LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	140,338	11,929	426	152,693	43,978	196,671	1,453	198,124			1
2	Food Purchase		143,073		143,073		143,073	(78)	142,995			2
3	Housekeeping		255	197,434	197,689		197,689		197,689			3
4	Laundry		6,801	64,800	71,601		71,601		71,601			4
5	Heat and Other Utilities							1,049	1,049			5
6	Maintenance	27,780	5,067	39,082	71,929	8,751	80,680	(5,112)	75,568			6
7	Other (specify):* Please See Attached											7
8	**TOTAL General Services**	168,118	167,125	301,742	636,985	52,729	689,714	(2,688)	687,026			8
	B. Health Care and Programs											
9	Medical Director			12,750	12,750		12,750		12,750			9
10	Nursing and Medical Records	1,348,228	172,665	54,439	1,575,332	425,605	2,000,937		2,000,937			10
10a	Therapy		15,079	240,388	255,467		255,467		255,467			10a
11	Activities	32,219	2,943	40	35,202	10,149	45,351		45,351			11
12	Social Services	37,321		4,618	41,939	11,756	53,695		53,695			12
13	Nurse Aide Training											13
14	Program Transportation							20	20			14
15	Other (specify):* Please See Attached											15
16	**TOTAL Health Care and Programs**	1,417,768	190,687	312,235	1,920,690	447,510	2,368,200	20	2,368,220			16
	C. General Administration											
17	Administrative	62,067		174,616	236,683	18,890	255,573	(73,270)	182,303			17
18	Directors Fees											18
19	Professional Services			48,420	48,420		48,420	5,913	54,333			19
20	Dues, Fees, Subscriptions & Promotions			48,650	48,650		48,650	(36,125)	12,525			20
21	Clerical & General Office Expenses	101,041	16,029	37,435	154,505	31,154	185,659	80,176	265,835			21
22	Employee Benefits & Payroll Taxes			408,824	408,824	(550,945)	(142,121)	152,167	10,046			22
23	Inservice Training & Education			2,840	2,840		2,840		2,840			23
24	Travel and Seminar			10,359	10,359		10,359	6,532	16,891			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,595	69,595		69,595	(49,460)	20,135			26
27	Other (specify):* Please See Attached			31,552	31,552		31,552	(31,583)	(31)			27
28	**TOTAL General Administration**	163,108	16,029	832,291	1,011,428	(500,901)	510,527	54,351	564,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,748,994	373,841	1,446,268	3,569,103	(662)	3,568,441	51,683	3,620,124			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab - University #0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,444	3,444		3,444	38,839	42,283			30
31	Amortization of Pre-Op. & Org.							9,949	9,949			31
32	Interest			50,286	50,286		50,286	(39,492)	10,794			32
33	Real Estate Taxes			47,417	47,417		47,417	(2,006)	45,411			33
34	Rent-Facility & Grounds			226,172	226,172		226,172	2,540	228,712			34
35	Rent-Equipment & Vehicles			15,918	15,918	662	16,580	5,625	22,205			35
36	Other (specify):* Please See Attached			1,467	1,467		1,467	11,734	13,201			36
37	**TOTAL Ownership**			344,704	344,704	662	345,366	27,189	372,555			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,814	75,814		75,814		75,814			42
43	Other (specify):* Please See Attache		5,646	7,557	13,203		13,203		13,203			43
44	**TOTAL Special Cost Centers**		5,646	83,371	89,017		89,017		89,017			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,748,994	379,487	1,874,343	4,002,824		4,002,824	78,872	4,081,696			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	256	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78)	2		13
14	Non-Care Related Interest	(86)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(35,649)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(848)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,917)	27		24
25	Fund Raising, Advertising and Promotional	(556)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(11,820)	29		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (68,699)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	147,571	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 147,571		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 78,872		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SunBridge Care & Rehab - University

ID# **0042697**

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$		1
2	Rental Income			2
3	Personal Laundry Income			3
4	Rebates & Refunds			4
5	Sales Tax on food			5
6	Interest Income			6
7	Penalties and Late Fees			7
8	Contributions			8
9	Legal Services (Collection Fees)			9
10	Bad Debt Expense			10
11	Public Relations			11
12	Vending Machine Revenue	1,198	1	12
13	Adjust Physical Therapy cost to actual	0	10a	13
14	Management Fee Exp (Ic00)	(77,528)	17	14
15	Chamber of Commerce	(867)	20	15
16	Regional Public Relations	0	20	16
17	Royalty Fees (IC00)	0	20	17
18	Other Non-Oper Inc	0	21	18
19	Regional Marketing Director	0	21	19
20	Expense Minor Durable Equipment	(672)	21	20
21	Expense Minor Durable Equipment	187	21	21
22	Franchise\Intangible T	0	21	22
23	Expense Minor Durable Equipment	(2,006)	33	23
24	Resident Expenses	(2,830)	27	24
25	Depreciation Expense - Equipment	16,489	30	25
26	Amortization - Leasehold Expense	22,350	30	26
27	Depr Exp Minor Durable Equipment	0	30	27
28	Barber/Beauty Inc	0	40	28
29	Patient Personal Services	0	21	29
30	Pat Personal Svcs Inc	0	21	30
31	Incontinency Income	0	10	31
32	Equip Rental Income	0	35	32
33	Community Awareness	(8,372)	27	33
34	Special Events	92	27	34
35	Miscellaneous Exp (IC00)	0	27	35
36	Depr - Equipment (IC00)	0	27	36
37	Interest Expense - Interco (IC00)	(31,965)	32	37
38	FAS 121 Charge	0	21	38
39	Interest Expense - Net Assets	0	32	39
40	Pto Accrual Adjustment	0	22	40
41	Pto Accrual Adjustment to Actual	3,121	22	41
42	Health Insurance	195,784	22	42
43	Worker's Compensation Audit Adjustment	0	22	43
44	Worker's Compensation Adjustment	(56,784)	22	44
45	Professional & General Liability Adjustment	(51,367)	26	45
46	Property Insurance Adjustment	580	26	46
47	Auto Insurance Adjustment	(996)	26	47
48	Interest Expense	(18,235)	32	48
49	**Total**	(11,820)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	1,453	0	0	0	0	0	0	0	0	0	0	1,453	1
2	Food Purchase	(78)	0	0	0	0	0	0	0	0	0	0	(78)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,049	0	0	0	0	0	0	0	0	0	1,049	5
6	Maintenance	0	360	(5,472)	0	0	0	0	0	0	0	0	(5,112)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,375	1,409	(5,472)	0	0	0	0	0	0	0	0	(2,688)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	20	0	0	0	0	0	0	0	0	0	20	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	20	0	0	0	0	0	0	0	0	0	20	16
	C. General Administration													
17	Administrative	(77,528)	4,258	0	0	0	0	0	0	0	0	0	(73,270)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(848)	6,761	0	0	0	0	0	0	0	0	0	5,913	19
20	Fees, Subscriptions & Promotions	(36,516)	391	0	0	0	0	0	0	0	0	0	(36,125)	20
21	Clerical & General Office Expenses	(485)	80,661	0	0	0	0	0	0	0	0	0	80,176	21
22	Employee Benefits & Payroll Taxes	142,121	10,046	0	0	0	0	0	0	0	0	0	152,167	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,532	0	0	0	0	0	0	0	0	0	6,532	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(51,783)	2,323	0	0	0	0	0	0	0	0	0	(49,460)	26
27	Other (specify):*	(31,583)	0	0	0	0	0	0	0	0	0	0	(31,583)	27
28	**TOTAL General Administration**	(56,621)	110,972	0	0	0	0	0	0	0	0	0	54,351	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,246)	112,401	(5,472)	0	0	0	0	0	0	0	0	51,683	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	38,839	0	0	0	0	0	0	0	0	0	0	38,839	30
31	Amortization of Pre-Op. & Org.	0	9,949	0	0	0	0	0	0	0	0	0	9,949	31
32	Interest	(50,286)	0	10,794	0	0	0	0	0	0	0	0	(39,492)	32
33	Real Estate Taxes	(2,006)	0	0	0	0	0	0	0	0	0	0	(2,006)	33
34	Rent-Facility & Grounds	0	0	2,540	0	0	0	0	0	0	0	0	2,540	34
35	Rent-Equipment & Vehicles	0	0	5,625	0	0	0	0	0	0	0	0	5,625	35
36	Other (specify):*	0	10,860	874	0	0	0	0	0	0	0	0	11,734	36
37	**TOTAL Ownership**	(13,453)	20,809	19,833	0	0	0	0	0	0	0	0	27,189	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(68,699)	133,210	14,361	0	0	0	0	0	0	0	0	78,872	45

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100%	Please see attached	Please see attached	See 6A	See 6A	See 6A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$	SunBridge Healthcare Corporation	100.00%	$ 4,258	$ 4,258	1
2	V	5	Heat and Other Utilities		SunBridge Healthcare Corporation	100.00%	1,049	1,049	2
3	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	360	360	3
4	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	20	20	4
5	V	19	Legal & Accounting		SunBridge Healthcare Corporation	100.00%	6,761	6,761	5
6	V	20	Dues and Subscriptions		SunBridge Healthcare Corporation	100.00%	391	391	6
7	V	21	General Office Expenses		SunBridge Healthcare Corporation	100.00%	80,661	80,661	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	10,046	10,046	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	6,532	6,532	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	2,323	2,323	10
11	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	10,860	10,860	11
12	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	9,949	9,949	12
13	V								13
14	Total			$			$ 133,210	$ * 133,210	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 10,794	$ 10,794	15
16	V	36	Property Taxes		SunBridge Healthcare Corporation	100.00%	874	874	16
17	V	34	Facility Lease		SunBridge Healthcare Corporation	100.00%	2,540	2,540	17
18	V	35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	5,625	5,625	18
19	V	10	Pharmacy Expense	116,098	SunScript Pharmacy Corporation	100.00%	116,098		19
20	V	10a	Physical,Speech,Occupational Ther	237,367	SunDance Rehabilitation Corporation	100.00%	237,367		20
21	V	10a	Respiratory Therapy	8,713	SunCare Respiratory	100.00%	8,713		21
22	V	10	Medical Supplies & Equipment Rental	3,289	SunChoice Medical Supply	100.00%	3,289		22
23	V	6	Software	7,200	Shared Healthcare System, Inc.	70.40%	1,728	(5,472)	23
24	V	10	Medical Supplies & Equipment Rental	68,383	Medline Industries, Inc.	0.00%	68,383		24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 441,050			$ 455,411	$ * 14,361	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	1,557,938,434	311	$ 1,692,927	$ 1,692,927	3,893,329	$ 4,231	1
2	5	Heat and Other Utilities	Accumulated Cost	1,557,938,434	311	387,282		3,893,329	968	2
3	6	Maintenance	Accumulated Cost	1,557,938,434	311	133,507		3,893,329	334	3
4	14	Program Transportation	Accumulated Cost	1,557,938,434	311	8,045		3,893,329	20	4
5	19	Legal & Accounting	Accumulated Cost	1,557,938,434	311	2,667,822		3,893,329	6,667	5
6	20	Dues and Subscriptions	Accumulated Cost	1,557,938,434	311	94,945		3,893,329	237	6
7	21	General Office Expenses	Accumulated Cost	1,557,938,434	311	25,594,615	19,078,284	3,893,329	63,962	7
8	22	Employee Benefits	Accumulated Cost	1,557,938,434	311	2,972,051		3,893,329	7,427	8
9	24	Travel	Accumulated Cost	1,557,938,434	311	1,503,862		3,893,329	3,758	9
10	26	Insurance	Accumulated Cost	1,557,938,434	311	923,577		3,893,329	2,308	10
11	36	Depreciation	Accumulated Cost	1,557,938,434	311	4,318,111		3,893,329	10,791	11
12	31	Amortization	Accumulated Cost	1,557,938,434	311	3,955,690		3,893,329	9,885	12
13	32	Interest	Accumulated Cost	1,557,938,434	311	4,291,770		3,893,329	10,725	13
14	36	Property Taxes	Accumulated Cost	1,557,938,434	311	346,868		3,893,329	867	14
15	34	Facility Lease	Accumulated Cost	1,557,938,434	311	588,958		3,893,329	1,472	15
16	35	Equipment Lease	Accumulated Cost	1,557,938,434	311	2,017,657		3,893,329	5,042	16
17										17
18										18
19		Total from attached Page 8a	Accumulated Cost	5,474					0	19
20		Total from attached Page 8b	Accumulated Cost	18,875					0	20
21										21
22			Total Units =							22
23			1,557,938,434							23
24										24
25	TOTALS					$ 51,497,687	$ 20,771,211		$ 128,694	25

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	300,771,607	75	$ 464	$ 464	3,893,329	$ 6	1
2	5	Heat and Other Utilities	Accumulated Cost	300,771,607	75	104		3,893,329	1	2
3	6	Maintenance	Accumulated Cost	300,771,607	75	535		3,893,329	7	3
4	14	Program Transportation	Accumulated Cost	300,771,607	75	2		3,893,329		4
5	19	Legal & Accounting	Accumulated Cost	300,771,607	75	560		3,893,329	7	5
6	20	Dues and Subscriptions	Accumulated Cost	300,771,607	75	170		3,893,329	2	6
7	21	General Office Expenses	Accumulated Cost	300,771,607	75	276,688	172,279	3,893,329	3,582	7
8	22	Employee Benefits	Accumulated Cost	300,771,607	75	50,438		3,893,329	653	8
9	24	Travel	Accumulated Cost	300,771,607	75	55,683		3,893,329	721	9
10	26	Insurance	Accumulated Cost	300,771,607	75	253		3,893,329	3	10
11	36	Depreciation	Accumulated Cost	300,771,607	75	1,183		3,893,329	15	11
12	31	Amortization	Accumulated Cost	300,771,607	75	1,084		3,893,329	14	12
13	32	Interest	Accumulated Cost	300,771,607	75	1,176		3,893,329	15	13
14	36	Property Taxes	Accumulated Cost	300,771,607	75	247		3,893,329	3	14
15	34	Facility Lease	Accumulated Cost	300,771,607	75	26,276		3,893,329	340	15
16	35	Equipment Lease	Accumulated Cost	300,771,607	75	8,127		3,893,329	105	16
17										17
18										18
19										19
20										20
21			Total Units =							21
22			300,771,607							22
23										23
24										24
25	TOTALS					$ 422,990	$ 172,743		$ 5,474	25

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	154,186,355	41	$ 844	$ 844	3,893,329	$ 21	1
2	5	Heat and Other Utilities	Accumulated Cost	154,186,355	41	3,158		3,893,329	80	2
3	6	Maintenance	Accumulated Cost	154,186,355	41	735		3,893,329	19	3
4	14	Program Transportation	Accumulated Cost	154,186,355	41	3		3,893,329		4
5	19	Legal & Accounting	Accumulated Cost	154,186,355	41	3,434		3,893,329	87	5
6	20	Dues and Subscriptions	Accumulated Cost	154,186,355	41	6,010		3,893,329	152	6
7	21	General Office Expenses	Accumulated Cost	154,186,355	41	519,488	401,422	3,893,329	13,117	7
8	22	Employee Benefits	Accumulated Cost	154,186,355	41	77,848		3,893,329	1,966	8
9	24	Travel	Accumulated Cost	154,186,355	41	81,286		3,893,329	2,053	9
10	26	Insurance	Accumulated Cost	154,186,355	41	461		3,893,329	12	10
11	36	Depreciation	Accumulated Cost	154,186,355	41	2,154		3,893,329	54	11
12	31	Amortization	Accumulated Cost	154,186,355	41	1,973		3,893,329	50	12
13	32	Interest	Accumulated Cost	154,186,355	41	2,140		3,893,329	54	13
14	36	Property Taxes	Accumulated Cost	154,186,355	41	173		3,893,329	4	14
15	34	Facility Lease	Accumulated Cost	154,186,355	41	28,835		3,893,329	728	15
16	35	Equipment Lease	Accumulated Cost	154,186,355	41	18,944		3,893,329	478	16
17										17
18										18
19										19
20			Total Units =							20
21			154186355							21
22										22
23										23
24										24
25	TOTALS					$ 747,486	$ 402,266		$ 18,875	25

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Interest from Page 8-8b										10,794	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 10,794	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 10,794	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	50,423	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	48,417	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,006)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	47,417	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,410	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	9,098	8
1997	41,660	9
1998	43,034	10
1999	43,771	11
2000	48,417	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SunBridge Care & Rehab - University COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0042697

CONTACT PERSON REGARDING THIS REPORT Sylvia Moreno

TELEPHONE (505) 468-4984 FAX #: (505)468-4969

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-2-15-15-11-201-002-001	1095 University Drive	$ 48,416.55	$ 48,416.55
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,416.55	$ 48,416.55

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,290 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	5 TON AC/HEATING UNIT/COMFORT			1997	10,741						9
10	ZONELINE HEAT-COOL WALL SYSTEM			1997	1,582						10
11	WALL A/C/DIRECT SUPPLY			1997	620						11
12	WALL A/C/DIRECT SUPPLY			1997	769						12
13	DOOR ALARMS (7)/HEPPTECH			1997	1,139	25,662		25,662		74,257	13
14	A/C/DIRECT SUPPLY			1997	849						14
15	A/C HEATING UNIT/DIRECT SUPPLY			1998	849						15
16	A/C UNIT/DIRECT SUPPLY			1998	849						16
17	WALL A/C UNIT/DIRECT SUPPLY			1998	672						17
18	A/C UNIT/DIRECT SUPPLY			1998	849						18
19	A/C WALL/DIRECT SUPPLY			1998	608						19
20	VINYL FLOORING/INTERIOR CON/MO			1998	1,953						20
21	A/C HEAT UNITS-2/DIRECT SUPPLY			1998	1,447						21
22	P171 - REFURB/WALLPAPER			1998	9,835						22
23	P171 - REFURB/DRAPERIES			1998	2,649						23
24	P171 - REFURB/VINYL FLOOR			1998	4,129						24
25	P171 - REFURB/LIGHTING			1998	1,307						25
26	P171 - PROJECT/ASPHALT PARKING			1998	48,250						26
27	P171 - REFURB/CANOPY			1998	4,569						27
28	P171 - REFURB/WOOD RAILING			1998	1,829						28
29	P171 - REFURB/CONTRACTORS FEE			1998	23,551						29
30	WTR MIXING VALVE/DIRECT SUPPLY			1998	1,116						30
31	SIGN-EXTERIOR LOGO/ACME WILEY			1998	6,343						31
32	CUBICLE CURTAINS(8)/MULTI			1998	989						32
33	HT WATER HEATER/FOX SUPPLY			1998	2,716						33
34	ROOFING SHINGLES			1998	2,680						34
35	SINK-KOHLER CLINICAL\DIRECT			1998	802						35
36	PAINT ROOMS & WARDS			1999	6,000						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINT HALLWAYS/DOORWAYS	1999	$ 7,200	$		$	$	$	37
38	FLOOR & WALL MOLDING	1999	2,337						38
39	ANTI-FREEZE LOOP/SMOKING	1999	6,600						39
40	REPLACE SIDEWALK	1999	12,150						40
41	REPLACE ROOFING	1999	7,000						41
42	Comp/Phone Cabling Upgrade	1999	3,460						42
43	Wood Doors	1999	2,575						43
44	HEAT/COOL UNIT	2000	617						44
45	ELECTRIC WATER HEATER	2000	2,721						45
46	ROOF COVERING	2001	74,180						46
47	DOOR LOCK SYSTEM	2001	1,851						47
48	VINYL FLOORS	2001	13,944						48
49	KITCHEN VINYL FLOOR	2001	5,179						49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 279,506	$ 25,662		$ 25,662	$	$ 74,257	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 134,423	$ 16,316	$ 16,316	$		$ 56,920	71
72	Current Year Purchases	3,912	305	305			305	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 138,335	$ 16,621	$ 16,621	$		$ 57,225	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 417,841	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,283	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,283	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 131,482	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978	122	6/1/97	$ 226,172	14	14	3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 226,172 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/1/97
Ending 5/31/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 228,558
13.	12/31/2003	$ 234,674
14.	12/31/2004	$ 241,128

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 12,759 Description: Please See Attached 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Transport	1997 Ford Club Wagon	$ 282.61	$ 3,159	17
18					18
19					19
20					20
21	TOTAL		$ 282.61	$ 3,159	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	mods	$	6,591	$ 88,974	$ 4,550	6,591	$ 93,524	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	mods		2,595	35,037	712	2,595	35,749	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	mods		7,848	105,943	2,504	7,848	108,447	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10 Col 2	# of prescrpts			36,730	64,450		101,180	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): IV Therapy & LALT	Line 10a Col 3				10,432	7,314		17,746	13
14	TOTAL			$	17,034	$ 277,116	$ 79,530	17,034	$ 356,646	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 366,449	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	22,485		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	558		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Please See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 389,492	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	279,506		15
16	Equipment, at Historical Cost	138,335		16
17	Accumulated Depreciation (book methods)	(131,482)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	28,474		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,474)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Please See Attached	67,099		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 353,458	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 742,950	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (60,014)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(128,585)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(114,373)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(50,837)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Please See Attached	(70,614)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (424,423)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		(2,471,315)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,471,315)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,895,738)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,152,788	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (742,950)	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,476,303	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,476,303	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,014	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations**	(423,529)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (323,515)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,152,788	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,438,435	1
2	Discounts and Allowances for all Levels	433,540	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,871,975	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	136,334	6
7	Oxygen	21,678	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 158,012	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,633	13
14	Non-Patient Meals	256	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	23,510	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,581	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,587	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 71,567	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	86	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 86	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please See Attached	1,198	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,198	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,102,838	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	636,985	31
32	Health Care	1,920,690	32
33	General Administration	1,011,428	33
	B. Capital Expense		
34	Ownership	344,704	34
	C. Ancillary Expense		
35	Special Cost Centers	89,017	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,002,824	40
41	**Income before Income Taxes (line 30 minus line 40)****	100,014	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 100,014	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,271	3,112	$ 76,612	$ 24.62	1
2	Assistant Director of Nursing	1,388	1,564	33,244	21.26	2
3	Registered Nurses	9,536	8,506	163,676	19.24	3
4	Licensed Practical Nurses	26,335	26,016	419,716	16.13	4
5	Nurse Aides & Orderlies	66,969	64,345	640,241	9.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,676	1,525	15,102	9.90	9
10	Activity Assistants	2,878	2,812	17,117	6.09	10
11	Social Service Workers	3,610	3,419	37,321	10.91	11
12	Dietician	1,040	1,186	16,132	13.60	12
13	Food Service Supervisor	1,555	1,487	21,494	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,320	14,667	102,711	7.00	15
16	Dishwashers					16
17	Maintenance Workers	1,985	1,938	27,780	14.33	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,080	1,880	61,864	32.91	20
21	Assistant Administrator					21
22	Other Administrative	5,273	4,839	50,893	10.52	22
23	Office Manager	649	781	12,075	15.45	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,436	3,951	53,016	13.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,000	142,030	$ 1,748,994 *	$ 12.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	12	$ 426	1.3	35
36	Medical Director	675/mo &1500/m	12,750	9.1	36
37	Medical Records Consultant	270/Bi-mo	3,233	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	7,320	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	107	4,618	10.3	45
46	Other(specify) A&G Consulting Fees	9	846	19.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	145	$ 29,193		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kyle Moore	Administrator	0	$ 23,053
Jill Henson	Administrator	0	6,473
Mark A. Walker	Administrator	0	32,541
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,067

B. Administrative - Other

Description	Amount
Management Fees	$ 77,528
Regional Allocation	97,088
TOTAL (agree to Schedule V, line 17, col. 3)	$ 174,616
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sentry Plus	SB Name Badges	$ 83
Esparza King	Design of Strategic Plan	38
Eproperty Tax	Real & Personal Prop Tax Info	100
Rick Johnson & CO	Advertising	33
Maun Lemke Inc.	Consultant Fees	846
Meridian Resources Inc	Consultant Fees	170
Taliana Rubin & Buckley	Legal Fees	848
Gardner Carton Dougals	Legal Fees	601
Duane Morris & Hecksclay	Legal Fees	5,700
Legal Fees(?)	Legal Fees	40,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 48,420

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Employee Benefits	10,046
TOTAL (agree to Schedule V, line 22, col.8)	$ 10,046

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 340
Advertising: Employee Recruitment	7,685
Health Care Worker Background Check	
(Indicate # of checks performed)	
Pen. & late Fees\Chamber of Commerce	33,932
IL Health Care Assoc\Bank Svc Charges	6,597
H.O. Dues & Subs\Judy Smith	431
Creative Forcasting/Reminisce	56
Less: Pen. & late Fees\Chamber of Comm	(36,516)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,525

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 821
In-State Travel	9,538
Home Office Travel	6,532
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,891

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab - University # 0042697 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab - University **#** 0042697 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Assoc. $5754.38**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,115** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,814**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arthur Andersen & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Financial Statements are consolidated**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

03.01.01.	140338	43978	0	184315
03.01.02.	11929	0	0	11929
03.01.03.	426	0	0	426
03.01.05.	0	0	0	0
03.02.02.	143073	0	1375	144448
03.03.01.	0	0	0	0
03.03.02.	255	0	0	255
03.03.03.	197434	0	0	197434
03.04.01.	0	0	0	0
03.04.02.	6801	0	0	6801
03.04.03.	64800	0	0	64800
03.06.01.	27780	8751	0	36531
03.06.02.	5067	0	0	5067
03.06.03.	39082	0	-672	38410
03.07.03.	0	0	0	0
03.09.01.	0	0	0	0
03.09.03.	12750	0	0	12750
03.10.01.	1348228	425605	0	1773833
03.10.02.	172665	0	0	172665
03.10.03.	54439	0	0	54439
03.10.05.	0	0	0	0
03.10.a.01	0	0	0	0
03.10.a.02	15079	0	0	15079
03.10.a.03	240388	0	0	240388
03.11.01.	32219	10149	0	42368
03.11.02.	2943	0	0	2943
03.11.03.	40	0	0	40
03.12.01.	37321	11756	0	49078
03.12.02.	0	0	0	0
03.12.03.	4618	0	0	4618
03.13.03.	0	0	0	0
03.14.03.	0	0	0	0
03.15.03.	0	0	0	0
03.17.01.	62067	19552	0	81619
03.17.03.	174616	-662	-80327	93627
03.18.03.	0	0	0	0
03.19.03.	48420	0	-848	47572
03.20.03.	48650	0	-33932	14718
03.21.01.	101041	31154	0	132194
03.21.02.	16029	0	0	16029
03.21.03.	37435	0	187	37622
03.22.03.	408824	-550945	142121	0
03.23.03.	2840	0	0	2840
03.24.03.	10359	0	0	10359
03.26.03.	69595	0	-51783	17813
03.27.03.	31552	0	-31460	92
04.30.03.	3444	0	38839	42283
04.31.03.	0	0	0	0
04.32.03.	50286	0	-50286	0
04.33.03.	47417	0	-2006	45411
04.34.03.	226172	0	0	226172
04.34.05.	0	0	0	0
04.35.03.	15918	0	0	15918
04.35.05.	0	662	0	662
04.36.03.	1467	0	0	1467
04.38.03.	0	0	0	0
04.39.03.	0	0	0	0
04.40.02.	0	0	0	0
04.40.03.	0	0	0	0
04.41.03.	0	0	0	0
04.42.03.	75814	0	0	75814
04.43.02.	5646	0	0	5646
04.43.03.	7557	0	0	7557
17.01.	366449	0	0	366449
17.03.	22485	0	0	22485
17.04.	0	0	0	0
17.06.	558	0	0	558
17.07.	0	0	0	0
17.13.	0	0	0	0
17.14.	0	0	0	0
17.15.	62124	0	217382	279506
17.16.	3912	0	134423	138335
17.17.	-3444	0	-128038	-131482
17.19.	28474	0	0	28474
17.20.	-28474	0	0	-28474
17.22.	0	0	0	0
17.23.	67099	0	0	67099
17.26.	-60014	0	0	-60014
17.30.	-128585	0	0	-128585
17.31.	-114373	0	0	-114373
17.32.	-50837	0	0	-50837
17.36.	-70614	0	0	-70614
17.39.	0	0	0	0
17.43.	-2471315	0	0	-2471315
17.44.	0	0	0	0
17.47.	2476572	0	0	2476572
19.01.	-3438435	0	0	-3438435
19.02.	-433540	0	0	-433540
19.06.	-136334	0	0	-136334
19.07.	-21678	0	0	-21678
19.13.	-1633	0	0	-1633
19.14.	-256	0	0	-256
19.17.	-23510	0	0	-23510
19.19.	-32581	0	0	-32581
19.20.	0	0	0	0
19.21.	-13587	0	0	-13587
19.22.	0	0	0	0
19.25.	-86	0	0	-86
19.28.	-1198	0	0	-1198
19.28.a.	0	0	0	0